co-operators
Investments. Insurance. Advice.

OPTIONAL GROUP CRITICAL ILLNESS INSURANCE APPLICATION

GENERAL INFORMATION

This brochure is designed to outline the benefits for which you are eligible and does not create or confer any contractual or other rights. All rights with respect to the benefits of an insured person will be governed solely by the group policy issued by Co-operators Life Insurance Company.

WHY DO I NEED ADDITIONAL COVERAGE?

Statistics indicate that Canadian families require insurance coverage at a level of four to six times the annual household income. One of the most valuable assets that we as individuals possess, is the ability to earn an income. Loss of income as a result of medical illness can have a devastating effect on a family's lifestyle and dreams unless provisions are made for the replacement of lost income.

IS A MEDICAL EXAM REQUIRED?

Co-operators Life Insurance Company reserves the right to request a medical examination or other evidence at no expense to you. You will be notified directly if one is required.

WHEN DOES INSURANCE TAKE EFFECT?

Your coverage will take effect once you receive written confirmation from Co-operators Life Insurance Company.

HOW ARE PREMIUMS PAID?

Payment of premium is made by payroll deduction.

HOW DOES IT WORK?

Coverage is available in units as outlined in the rate sheet supplied to your plan sponsor. You can choose the amount of protection that is right for you.

As an example, a 34 year old person wishes to purchase 10 units =($50,000) of additional Critical Illness coverage. If the cost of this amount of coverage under this benefit amount was $1.00 per unit per month, then: $1.00 x 10 units = $10.00 per month.

HOW DO I APPLY?

To apply, complete the attached application form and forward to:

Co-operators Life Insurance Company
Group Medical Underwriting
1900 Albert Street Regina, SK S4P 4K8

Email: group_client_services@cooperators.ca

Fax: 1-866-889-9924

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CONTACT INFORMATION

Mail: Co-operators Life Insurance Company
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Regina, SK S4P 4K8
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Phone: 1-800-667-8164
Fax: 1-866-889-9924

INSTRUCTIONS

To avoid delays, please complete all information.

The completed form can be returned by email, fax, or the original can be mailed to the address provided.

This form must be received in our office within 60 days of the application being signed, otherwise a new application must be completed.

PLAN MEMBER INFORMATION

Group _____ Account _____ Certificate _____ Group Name _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Is plan member actively at work? ☐ Yes ☐ No If no, why? _____

APPLICANT INFORMATION

Applicant: ☐ Plan Member ☐ Spouse _____ (First Name) _____ (Initial) _____ (Last Name)

Mailing Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Email: _____

You acknowledge that data transmitted over the internet may be intercepted and that such transmission is at your own risk. If you no longer wish to communicate with Co-operators Life Insurance Company by email, please send notification to group_client_services@cooperators.ca

Phone Number: Home (____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth _____ (MMM/DD/YYYY) ☐ Male ☐ Female

Annual Salary $ _____ Occupation _____

COVERAGE AMOUNT

Existing Optional Critical Illness Amount: $ _____ (under this group)

New Total Amount Requested: $ _____

APPLICANT DECLARATION OF INSURABILITY

1. Have any of your parents or siblings been diagnosed before their 60th birthday with cancer, tumour, leukemia, lymphoma, Hodgkin's disease, heart disease, heart attack, coronary artery disease, stroke, high blood pressure, diabetes, polycystic kidney disease, kidney disorder, liver disorder, multiple sclerosis, Alzheimer's disease, dementia, Huntington's disease, Parkinson's disease, multiple sclerosis, or Amyotrophic Lateral sclerosis (ALS /Lou Gehrig's disease)? ☐ Yes ☐ No

   If yes, specify condition, relationship, and age at diagnosis _____

2. Have any of your parents, brothers or sisters had any hereditary disorders? ☐ Yes ☐ No

   If yes, specify (e.g. Huntington's chorea, polycystic kidney disease, etc.) _____

3. Have you had any symptoms of, or treatment for, any medical condition, disorder or ailment that resulted in your hospitalization within the last year? ☐ Yes ☐ No

   If yes, give details below:

Name of Disorder	Date of Onset & Duration MMM/DD/YYYY	Symptoms	Attending Physician or Hospital	Treatment & Results

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

4. Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg

Has your weight changed in the past year? ☐ Yes ☐ No

If so, how much? _____ Why? _____

5. Who is your regular physician or family doctor? _____

If none, walk-in clinic visited: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason and Result _____

6. Have you ever had or been told you had any of the following:

a) Chronic obstructive pulmonary disorder (COPD), emphysema, sleep apnea, tuberculosis, asthma, chronic bronchitis, or any other lung disease or disorder? ☐ Yes ☐ No

b) Stroke, transient ischemic attack (TIA), heart attack, heart surgery, heart murmur, coronary artery bypass or angioplasty, irregular heartbeat, a pacemaker, chest pain, or shortness of breath? ☐ Yes ☐ No

c) Gastrointestinal disorder such as ulcer, rectal bleeding, Crohn's disease, ulcerative colitis, diverticulitis, or any disorder of the intestines, the esophagus, the stomach or the pancreas? ☐ Yes ☐ No

d) Diabetes, endocrine disorder, kidney or bladder disease? ☐ Yes ☐ No

e) Cancer, tumour, polyp, cyst, dysplastic nevi, skin growth, mole removal, leukemia, lymphoma, melanoma, nodule, growth, abnormal pap smear or mammogram, abnormal PSA test, or any blood disorder? ☐ Yes ☐ No

f) Head injury, epilepsy, cognitive impairment, memory loss, muscle weakness, numbness, tingling, dizziness, paralysis, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Huntington's disease, Parkinson's disease, motor neuron disease, dementia, Alzheimer's disease, or brain disorder? ☐ Yes ☐ No

g) Neuritis, arthritis, rheumatism, back, spine, bone, joint, or muscle disorder? ☐ Yes ☐ No

h) Nervous or mental disorders, including depression, anxiety or suicidal thoughts? ☐ Yes ☐ No

i) Tested positive for HIV? ☐ Yes ☐ No

j) Disorder of eyes or ears, such as blindness, optical neuritis, tinnitus, or deafness? ☐ Yes ☐ No

k) Liver disease, or hepatitis, including hepatitis carrier state? ☐ Yes ☐ No

l) Any disease, impairment or deformity not named above? ☐ Yes ☐ No

If yes to any question in number 6, give details below:

Name of Disorder	Date of Onset & Duration MMM/DD/YYYY	Symptoms	Attending Physician or Hospital	Treatment & Results

7. Have you ever taken drugs, including marijuana and cocaine for other than medical purposes or been advised to reduce alcohol consumption or received or have been counselled to receive treatment for drug addiction or alcoholism? ☐ Yes ☐ No

If yes, give details including: Substance _____

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Amount consumed on each occasion _____ Date last used _____ (MMM/DD/YYYY)

8. Have you ever been refused Life or Critical Illness insurance or been offered such insurance on a modified basis in any way? ☐ Yes ☐ No

If yes, date _____ (MMM/DD/YYYY) Reason _____

9. Tobacco Use: Have you smoked or used any form of tobacco products, nicotine products or nicotine substitutes within the past twelve (12) months? ☐ Yes ☐ No

If yes, for how long? _____ how many per day? _____

10. Within the last 5 years, have you consulted a health care professional for any symptoms, illness, condition, check-up consultation or treatment not already mentioned above? ☐ Yes ☐ No

If yes, provide details _____

APPLICANT DECLARATION OF INSURABILITY (CONTINUED)

11. Within the last 5 years, have you had an electrocardiogram (ECG), x-ray, blood tests or other diagnostic tests such as a colonoscopy, mammogram, ultrasound, CT scan, magnetic resonance imaging (MRI) or echocardiogram that you have not already disclosed above? ☐ Yes ☐ No

    If yes, include details such as name of test, date and results _____

    _____

12. Are you awaiting a consultation with a health care professional or have you been advised to have any surgical operation, any tests or investigations which have not yet been completed or for which you have not received the results? ☐ Yes ☐ No

    If yes, provide details _____

13. Within the last 6 months, have you had any condition, disease, symptoms or complaints for which you have not consulted a physician or received treatment? ☐ Yes ☐ No

    If yes, provide details _____

PRIVACY

Co-operators Privacy Statement

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of your province of residence or Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about our revised privacy policy at www.cooperators.ca/privacy. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

APPLICANT AUTHORIZATION AND CONSENT

I have read and understood the privacy statement and I consent to the collection, use, retention and disclosure of my personal information or those of my dependants for the purposes stated above. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated.

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operators re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Signature _____ Date _____
(Spouse Signature) MMM/DD/YYYY

Signature _____ Date _____
(Plan Member Signature) MMM/DD/YYYY